

## **PUBLIC HEALTH COUNCIL**

Meeting of the Public Health Council, Tuesday, November 16, 1999 at 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Floor 2, Boston, Massachusetts. Present were: Dr. Howard K. Koh (Chairman); Dr. Clifford Askinazi, Ms. Shane Kearney Masaschi; Mr. Benjamin Rubin; Dr. Thomas Sterne; Ms. Janet Slemenda; Mr. Albert Sherman; (Mr. Joseph Sneider and Mr. Manthala George arrived late 10:10 a.m.) Also in attendance was Ms. Donna Levin, General Counsel.

Chairman Koh announced that notices had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30 A, Section 11A ½.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Dr. Susan Lett, Medical Director, Massachusetts Immunization Program, Ms. Joyce James, Director, and Ms. Holly Phelps, Consulting Analyst, Determination of Need Program; Dr. Paul Dreyer, Director, Division of Health Care Quality; Mr. Howard Wensley, Director, Division of Community Sanitation; and Mr. Paul Hunter, Acting Director, and Mr. Roy Petre, Assistant Director, Childhood Lead Poisoning Prevention Program.

### **PERSONNEL ACTIONS:**

In a letter dated November 3, 1999, Blake Molleur, Executive Director, Western Massachusetts Hospital, recommended approval of the reappointments to the consultant medical staff of Western Massachusetts Hospital, Westfield. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted unanimously: Chairman Koh, Dr. Askinazi, Ms. Kearney-Masaschi, Mr. Rubin, Mr. Sherman, Ms. Slemenda, and Dr. Sterne approved; [Mr. George and Mr. Sneider not present to vote] That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6 the following reappointments to the consultant staff of Western Massachusetts Hospital be approved:

<b><u>REAPPOINTMENTS:</u></b>	<b><u>RESPONSIBILITY:</u></b>	<b><u>MED. LICENSE NO.:</u></b>
Lincoln Russin, M.D.	Radiology	39605
Murray Watnick, M.D.	Radiology	29482

In a letter dated November 4, 1999, Katherine Domoto, M.D., Associate Director for Medicine, Tewksbury Hospital, recommended approval of the appointments and reappointments to the affiliate, active, allied and consultant medical staffs of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted unanimously: Chairman Koh, Dr. Sterne, Ms. Kearney-Masaschi, Mr. Rubin, Mr. Sherman, Ms. Slemenda, and Dr. Sterne [Mr. George

and Mr. Sneider not present to vote] That, in accordance with the recommendation of the recommendation of the Associate Executive Director of Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointments and reappointments to the affiliate, active, allied and consultant medical staffs of Tewksbury Hospital be approved for a period of two years beginning November 1, 1999 to November 1, 2001.

<b><u>APPOINTMENTS:</u></b>	<b><u>MASS. LICENSE NO.:</u></b>	<b><u>SPECIALTY:</u></b>
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Douglas Kraut, DMD	19766	Dentistry
Kathleen Brady, MD	60484	Psychiatry
Lydia Fazzio, MD	159241	Psychiatry

<b><u>REAPPOINTMENTS:</u></b>	<b><u>MASS. LICENSE NO:</u></b>	<b><u>SPECIALTY:</u></b>
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John Duggan, OD	2186	Allied
Shirish Desai, MD	40000	Active/Internal Medicine
Svetlana Kaufman	50317	Active/Internal Medicine
Mark Brown, MD	31013	Affiliate/Internal Medicine

In a letter dated November 8, 1999, Robert D. Wakefield, Executive Director, Lemuel Shattuck Hospital, recommended approval of the initial appointments and reappointments to the active and consultant medical staffs of Lemuel Shattuck Hospital, Jamaica Plain. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments and reappointments to the medical staff of Lemuel Shattuck Hospital be approved:

<b><u>APPOINTMENTS:</u></b>	<b><u>MED. LICENSE NO.:</u></b>	<b><u>RESPONSIBILITY:</u></b>
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David Cherniak, MD	159590	Consultant/Radiology
Harriet Scheft, MD	78086	Active/Psychiatry
William Pirl, MD	150772	Active/Psychiatry

<b><u>REAPPOINTMENTS:</u></b>	<b><u>MED. LICENSE NO.:</u></b>	<b><u>RESPONSIBILITY:</u></b>
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Carol Amick, DMD	29350	Active/Pathology
Frank Davidson, MD	33520	Active/Pulmonary
Susan Goldstein, MD	36092	Consultant/Radiology
John M. Harris, MD	32488	Consultant/Physical Med.
Daniel Matloff, MD	40154	Active/Gastroenterology
Kenneth Mitchell, MD	80748	Active/Psychiatry
Richard Patten, MD	75891	Consultant/Cardiology
Victoria Shea, MD	53737	Active/Psychiatry

Elizabeth Tarnell, MD  
Robert Tarpy, MD

73363  
72824

Consultant/Pulmonary  
Consultant/Pulmonary

**PRESENTATION:**

**“HEALTH CARE PROXY DAY – NOVEMBER 26, 1999”**

**PRESENTED BY MICHAEL CANTOR, M.D., CHAIRMAN OF THE  
MASSACHUSETTS MEDICAL SOCIETY COMMITTEE ON ADVANCE  
DIRECTIVES:**

Dr. Michael Cantor, Chairman of the Massachusetts Medical Society’s Committee on Advance Directives, said, “There are people all over this Commonwealth who every single day are unable to make decisions for themselves, and others have to speak for them. I’m not just talking about the people in the emergency room who come in after a trauma. I’m not just talking about the older people in nursing homes, but the people who day in, day out, people with psychiatric illnesses, people who fall ill, people who have minor surgical procedures where something goes wrong, and decisions need to be made about what should happen to them, and what treatments they need. We need someone, each of us, to speak for us if we are unable to do so. In Massachusetts, the Legislature, in 1991, actually passed a law, the Health Care Proxy Law, which allows us to appoint an agent to fill out a Health Care Proxy Form, which says that if I am unable to speak for myself, I want this person to speak for me. We are relatively unique in only three states that don’t recognize living wills, pieces of paper that say if I become terminally ill, I would not want this, I would not want that, etc., ...What we need to do in our state is to have, therefore, many health care proxies...”

Dr. Cantor continued, “We in our committee realize that it is time for us to take a stand. The Medical Society passed a resolution making the day after Thanksgiving Health Care Proxy Day, because we think this is the time when people should sit together with the people they love, talk about what choices they would want, and to make certain that when they do need to make these difficult decisions, that their interests would be protected. This is our first year and we have been extremely lucky that we have had the Governor issue a Proclamation. We have also had events in Springfield and in Worcester getting the medical, legal, and nursing leaders to say that what we need to do this year is to lead by example. To get doctors, lawyers, nurses, social workers and clergy – the people who sit every day with people who are thinking about making a health care proxy – to get these people to lead by example. We also have a website which is [www.healthcareproxy.org](http://www.healthcareproxy.org). We believe very strongly that only by taking control of our lives and our decisions, can we make certain that the people of this Commonwealth have the best health care that they want. No more health care than they need, and no less...So, I would like to urge everyone to celebrate this first Health Care Proxy Day with us by reviewing their choices, making certain they have a health care proxy, and spreading the word to others.”

**“MASSACHUSETTS TOBACCO CONTROL PROGRAM RESULTS”:**  
**PRESENTED BY LOIS BIENER, PHD, SENIOR RESEARCH FELLOW,**  
**U.MASS. CENTER SURVEY RESEARCH:**

Chairman Howard Koh, M.D., introduced the presentation. He said, “...We, as a public health community, understand that tobacco addiction is the greatest public health catastrophe of our time. We are ending a century that I believe will forever be known as the tobacco and cancer century. Fortunately, we have tremendous antismoking efforts here in Massachusetts that are leading the country, if not the world. I view them as a world-class cancer vaccine. And we now have results that show that despite national smoking rates that have been stuck, and stagnant, and unchanged for about a decade, we are seeing very exciting declines here in Massachusetts, which are an example of the power of prevention at its very best....”

Dr. Lois Biener, Ph.D., Senior Research Fellow, U. Mass. Center Survey Research, said in part, “...We are bringing a lot of good news to the Public Health Council today. It is a pleasure to report these latest findings...We did a large survey in 1993 at the start of the Massachusetts Tobacco Control Program. We did the Massachusetts Adult Tobacco Survey, which is a small monthly survey that has been carried out since March of 1995. We have a statistically significant reduction in smoking prevalence among adults in the state of Massachusetts. In 1993, the rate was 22.6 percent of the Massachusetts adults who at that time were smokers. In fiscal year 1999, that rate has gone down 15 percent, to 19.1 percent. Daily smokers have reduced even further. In 1993, 19 percent of the adult population smoked every day. In 1999, that has gone down to 13.7 percent. So that is really good news. Our reduction compares to essentially a stagnation in the United States. The last date that we have adult smoking rates for from the CDC is 1997. The smoking rate has hovered around the 25 percent point, starting in 1993. In Massachusetts, we have a gradual, steady reduction. A little bleep in 1998, but now in fiscal 1999, we are down below 20 percent to 19.1 percent. This is very good news. On average, our smokers were smoking a pack a day, and now we are down to 16.5 cigarettes per day, which is a significant reduction. Next, we looked at all smokers, all people who twelve months before we interviewed them reported to be smoking cigarettes. Then we computed the proportion of those people who were not smoking at all on the day that they were interviewed. When we did that in 1993, we found that 8.1 percent of people who had been smoking in the past year quit by the time we spoke to them. That was at the beginning of the Massachusetts Tobacco Control Program. In 1999, that number is 11.4 percent. So we see an increase in the rate of cessation among past year smokers. Next we looked at those smokers who, in the past year, made an attempt to quit by staying off cigarettes for at least 24 hours. When you look at those people, you see an even better story, where in 1993, 17.1 percent of the people who have made at least one quit attempt during the prior year quit by the time we spoke to them. In 1999, 24 percent of the smokers who had tried to quit had been successful....Essentially, the proportion of smokers who are trying to quit has stayed the same. What we see is that the people who are trying are more likely to be successful. ”

“Next, for the comparison of smoking rates among 14 to 17 year olds in Massachusetts in 1999 versus the baseline, in 1993, almost 55 percent of kids in this age group had tried smoking. In 1999, only 47 percent had tried smoking. It is still a large number, but at least it is going in the right direction. That reduction does not reach the typical .05 level of significance that scientists usually require. It is a trend. Significant at the .10 level, but nevertheless, this is in a context of smoking rates among teens in the rest of the country that are increasing. That’s really good news for Massachusetts...a trend in the right direction. In conclusion, we see that smoking rates among Massachusetts adults have declined 15 percent since 1993; from 22.6 to 19.1 percent. And this corresponds to approximately 153,000 fewer smokers today in Massachusetts. The rate of daily smoking has declined 28 percent; from 19 percent to 13.7. ...We see an increase in the rate of success among those who are attempting to quit, and a reduction in experimentation among adolescents. I think what we need to conclude from these findings is that we have a story in Massachusetts that needs to be reported to other states that are now trying to figure out what to do about the tobacco settlement. We have progress in smoking in Massachusetts that is in sharp contrast to the stagnation in smoking rates in the rest of the United States. It is most likely the combination of policies, media, and cessation support that has increased the success rate of Massachusetts smokers who are trying to quit.”

Dr. Jeffrey Harris, M.D., Ph.D., Professor of Economics, MIT, said in part, “...Based on the number of cigarettes taxed per adult, smoking in Massachusetts is down more than in the rest of the country. One might argue that some of the decline in the number of cigarettes taxed is not necessarily a true decrease in smoking, but a decrease in the number of cigarettes that are purchased in Massachusetts. Next, mothers-to-be who are smoking during pregnancy. The information is based on a compilation of national birth certificates by the National Center of Health Statistics, in which at the time of a live birth, either the mother, father, or a health care provider makes an entry into the birth certificate as to whether the mother smoked during pregnancy. By 1996, a very substantial fraction of the states in the United States had such smoking data on birth certificates. The data showed that while there was a general decline in the percentage of mothers who smoked during pregnancy, something on the order of a little over 18 percent in 1990, down to a number on the order of 13 percent in 1996 for the U.S. as a whole, the decline in Massachusetts was much more striking. A bit over 25 percent of pregnant mothers smoked in Massachusetts in 1990. By 1996, the Massachusetts average is just a bit below the national average. It’s a little below 13 percent. The overall decline in Massachusetts was the largest decline of any individual state during this period. In particular, the decline was most striking in the years right before, and right after the enactment of Question One. There was a similar decline in the percentage of teenage mothers who smoked. That is, women who gave birth during the ages of 15 to 19. In Massachusetts, the decline in smoking by teenage mothers during the period from 1990 to 1996 was 28 percent, compared to the U.S. average decline of 16 percent...”

Chairman Koh said in part, “...I can say, as a Commissioner and as a physician, that we health professionals all have to care for hundreds of people who have suffered too much, and died too soon from tobacco addiction. This is not an accident. This occurs because the tobacco industry has spent the better part of this century marketing to children, and

addicting them early. The fact that we are seeing these very striking results in just six years, when the industry has been at it for a good part of this century, I think is really astonishing. I am thrilled to see that we have 153,000 fewer smokers now than we did six years ago. That translates into many lives saved. I believe we are about to enter a new century ready and poised to eradicate this horrible addiction from our Commonwealth. I would be thrilled to get the support of everyone in Massachusetts as we move forward into the year 2000, and say that we do not need this addiction in our society. Let me also thank everybody in the room. This is the work of thousands of people in Massachusetts who expressed their outrage that this level of addiction was going on; who voted for an initiative to do something about it. For people who are ireless advocates, for colleagues in my Public Health Department here who have dedicated their lives to doing something about this issue, this is a triumph for all of us, and it's a great moment for public health."

**INFORMATIONAL BRIEFING ON PROPOSED REGULATIONS ON  
MASSACHUSETTS IMMUNIZATION INFORMATION SYSTEM (MIIS) 105  
CMR 225.000:**

Dr. Susan Lett, M.D., MPH, Medical Director, Massachusetts Immunization Program, said in part, "...We are happy to be here today to inform the Council of our intent to hold public hearings for new regulations that we propose to be promulgated pertaining to the Massachusetts Immunization Information System. Basically, it is part of a national and statewide effort to increase childhood immunization rates, and it is a patient management tool. It allows health care providers to use every opportunity of a child's contact with the health care system to assess their immunization status, and make sure that they get all the immunizations that they require. Today, about a quarter of children change providers before they are two, and the median age of enrollment for Medicaid is nine to ten months. So incomplete immunization histories are a big problem. They also allow providers to identify those children who are not up to date, and remind them that they are due, or call them back. The immunization schedule is becoming increasingly complex. Today about sixteen shots are given to a child before they are two years of age. We think another four are probably going to be added just in the next calendar year, and the schedule is becoming increasingly complex. The system allows providers to look up and figure out what children are due for. The regulations have components that identify what an immunization record is, what it should consist of, who needs to report to the system pertaining to hospitals and providers. It also describes issues relating to consent, confidentiality, and security of the information that is in the system. It specifies in the regulations what type of information providers need to share, how they need to obtain consent in accordance with the Department's guidelines, and who they should share it with. And as was decided through this process, it would be shared with the child's current health care proviers, school, day care, and health personnel, and programs that the Department has identified that are engaged in follow-up of immunization of children who are behind. So, this outlines what the immunization information system is, what we hope the regulations will do, which will be mandate reporting to ensure completeness of the system, and to remove any barriers, on the part of providers, that they might have, in terms of concerns to ensure that privacy and confidentiality are maintained. We hope to

go to public hearing in the near future. Both the Massachusetts Medical Society, Massachusetts Chapters of the American Academy of Pediatric and Family Physicians have been involved in the development, as well as other groups, and have already endorsed this system and the regulation.”

#### **NO VOTE – INFORMATIONAL ONLY**

#### **INFORMATIONAL BRIEFING ON PROPOSED AMENDMENT TO DETERMINATION OF NEED REGULATIONS 105 CMR 100.000 GOVERNING APPLICATION FILING DATES FOR CONVALESCENT, NURSING AND REST HOME PROJECTS:**

Ms. Joyce James, Director, Determination of Need Program, said, “The purpose of this memorandum is to inform the Council that staff plans to hold a public hearing on a proposed amendment to the Determination of Need regulations. This amendment would essentially extend the filing date for new construction of convalescent, nursing, and rest homes from May 2000 to May 2005. About five years ago, March 1995, the Council amended the regulations, and at that time had extended the filing date from May 1995 to May 2000. The basis for that amendment was the need projections for that period showed that there were in excess of 3,000 surplus nursing home beds, and an equal number of beds that were approved, but had not been constructed. The Council decided that a five year hiatus would allow sufficient time to see whether or not changes that were occurring in the system would continue to affect utilization of nursing homes. The Council also reached the decision that there were sufficient beds within the system to meet the needs of nursing home patients by the year 2000. Trends observed were declining, low occupancies, and declined utilization among nursing homes. At that time too, the Governor had just signed the Assisted Living Facility bill. As we approached the year 2000, we decided that we would look at the need projections again to see whether or not there would be sufficient nursing home beds, as well as rest home beds, to meet the needs of the year 2005 population...There still continues to be a surplus of beds statewide. There are also approved beds that are still not constructed. Given the surplus beds, it has been determined that there are sufficient beds within the system to serve the needs of patients to the year 2005. Hence, the proposed amendment, which will allow the additional time to see if these trends continue, and the impact they will have on the need for nursing home beds.”

#### **NO VOTE – INFORMATION ONLY**

## **REGULATIONS:**

### **REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO LEAD POISONING PREVENTION AND CONTROL REGULATIONS – 105 CMR 460.000 (MODERATE RISK ABATEMENT PROGRAM AND OTHER MATTERS):**

Mr. Paul Hunter, Acting Director, Childhood Lead Poisoning Prevention Program introduced the regulations. He said, “We appeared before you earlier this year with draft regulations that would implement the final initiative resulting from 1994 amendments to the Lead Paint Law in Massachusetts. What these regulations will allow is for owners and their agents to remove and replace whole building components, including window sashes, woodwork, and other components. Through this effort, which will require a one-day training program for an owner or their agents, owners will become, “authorized persons” to conduct these activities and will in essence be able to do almost the entire work required to comply with the Massachusetts lead law. We held a public hearing and received fairly limited public comment either orally, or in writing. We have made a limited number of changes from the draft regulations to this final copy.”

Next, Mr. Roy Petre, Assistant Director, Childhood Lead Poisoning Prevention Program, said in part, “Another important change that we are making under these proposed, final regulations, is that we are establishing a new floor lead dust abatement clearance standard that must be met following abatement and before occupants can return to their home. This new standard will lower from 200 micrograms per square foot to 50 micrograms per square foot the floor dust lead standards. This is a major breakthrough in assuring that a thorough cleanup has been conducted. The U.S. Department of Housing and Urban Development conducted a study pooling data from virtually all available epidemiological studies that examined the very compelling relationship between dust lead and blood lead levels. These pooled analyses indicate that almost 95 percent of young children will be protected from developing an environmental intervention blood lead level of 15 micrograms per deciliter with this new standard. So this is going to be a major improvement in our overall abatement standards. In addition, we have reduced from 24 hours to 2 hours the waiting period between completion of active deleading and final cleanup. Again, HUD commissioned a study using laboratory and field data that demonstrated that using a two hour waiting period, a floor dust lead level clearance of 50 micrograms per square foot can routinely be met. This reduction in the waiting period will allow families to return to their homes a day sooner, thus reducing alternative housing costs. This set of regulations as a whole, with the new moderate risk program and these changes, is not only going to radically reduce the cost of abatement in the Commonwealth, but it will also mean that there will be many more homes that will be lead-safe for our children.”

After consideration, upon motion made and duly seconded, it was voted: unanimously to **approve the Request for Final Promulgation of Amendments to Lead Poisoning Prevention and Control Regulations – 105 CMR 460.000 (Moderate Risk Abatement Program and Other Matters);** that a copy of the approved regulations be forwarded

to the Secretary of the Commonwealth; and that a copy of the amended regulations be attached to and made a part of this record as **Exhibit Number 14,664**. A public hearing was held on July 19, 1999.

**REQUEST FOR PROMULGATION OF AMENDMENTS TO REGULATIONS ENTITLED “105 CMR 451.000: MINIMUM HEALTH AND SANITATION STANDARDS AND INSPECTION PROCEDURES FOR CORRECTIONAL FACILITIES”:**

Mr. Howard Wensley, Director, Division of Community Sanitation, said in part, “This is a request for promulgation of some final amendments to 105 CMR 451.000, dealing with conditions within correctional facilities...DOC requested the Department of Public Health to amend certain of the regulations because of some problems that that they were having within the institutions complying with them. The Department of Public Health had a hearing in April of 1999...The original regulations required that all toilets and hand wash sinks in correctional facilities be supplied directly with toilet paper and paper towels. The Department of Corrections changed their policy a while ago, whereby they provided each inmate with toilet paper and paper towels, rather than placing them at each toilet or hand wash sink. They had problems with what they consider to be improper use of these materials....The ultimate language that we are asking to be accepted is that all inmates be supplied with sufficient toilet paper and paper towels to meet their hygienic needs. We will continue to require the stocking of these materials at toilet rooms, that are separate from their living areas, utilized by staff. Another issue was reducing the hot water temperatures. The Department had required hot water to be provided at hand wash sinks between 110 and 130 degrees. The Department of Corrections asked initially that it be reduced to 110 to 120 degrees. The Department disagreed with the 110 degrees, because science showed that water tanks at 100 degrees would support growth of pathogens and bacteria. We did propose to reduce it to 120 degrees. The Mass. Sheriffs’ Association was opposed to that because they thought the range of 110 to 120 would be too difficult to manage. DOC also wanted the maximum of 120 because the American Correctional Association had a maximum of 120. Staff, after reviewing this, is recommending that the upper range stay at 130. And this, meanwhile, will allow Department of Corrections if they want to maintain it at 120...”

Mr. Wensley continued, “The other major concern that we are changing is on the amount of recreational space for the inmates. Originally, the regulations from the Department stated that they should have indoor recreational space of 60 to 100 square feet, 22 foot ceilings, and also 2 acres of available outdoor space for every 500 inmates. What we have done in the regulations is to adopt the standards of the American Correctional Association, and have language in there primarily that this is for new, or renovated facilities. We are asking for promulgation of these regulations. The Department also will be going back and reviewing the rest of the DOC regulations in lieu of some changes in legislation, and we will be going forth to public hearing again on some additional changes in the future.”

After consideration, upon motion made and duly seconded, it was voted: unanimously **to approve the Request for Promulgation of Amendments to Regulations Entitled “105 CMR 451.000: Minimum Health and Sanitation Standards and Inspection Procedures for Correctional Facilities”**; that a copy of the approved regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the amended regulations be attached to and made a part of this record as **Exhibit Number 14,665** . A public hearing was held on April 13, 1999.

#### **DETERMINATION OF NEED REGULATIONS:**

#### **PREVIOUSLY APPROVED DON PROJECT NO. 6-3942 OF ATLANTICARE MEDICAL CENTER – PROGRESS REPORT ON COMPLIANCE WITH CONDITIONS OF APPROVAL FOR TRANSFER OF OWNERSHIP:**

Ms. Holly Phelps, Consulting Analyst, Determination of Need Program, said in part, “...At its November 1997 meeting, the Council approved with conditions the transfer of ownership of AtlanticCare Medical Center to North Shore Medical Center (N.S.M.C.). This year, at the Council’s request, we are back here to report on AtlanticCare’s continuing progress to comply with conditions. The conditions included AtlanticCare’s commitment to maintain its level of free care, to enhance its interpreter services, to invest a specified amount, from 15 to 20 million dollars, in new facilities and services in the city of Lynn, coordinate and develop HIV and teenage pregnancy services, and to expand community health outreach, domestic violence, and transportation services. The conditions also included expanding primary care services, mental health, substance abuse services, and services for free care eligible patients. So there were quite a number of conditions and obligations that AtlanticCare agreed to, and a lot of progress has been made over the past couple of years. Staff’s review of the most recent reports that we have received from AtlanticCare and Lynn Health Task Force really show a very consistent picture that progress is continuing on compliance with those conditions. They also agree that there are a few areas where more work needs to be done. That is the level of free care provided, and expansion of primary care services, substance abuse, and mental health services, and services for free care eligible patients. And, for the record, I need to clarify something, and amend the staff report. Take out any reference to Boston Street Clinic, because I said that AtlanticCare was planning to move the clinic, and there was no basis for that in the progress report, all those references. In Lynn Task Force’s report, it expressed concern about AtlanticCare’s continuing commitment to meet the obligations embodied in the conditions in the schedule, in terms of the dollar commitment, to invest from 15 to 20 million dollars in new facilities and services in the city of Lynn. They have committed 11 million dollars in new facilities and services in the city of Lynn... They are well ahead of schedule. It is also true that Atlanticare has said that it is continuing to take seriously its obligations, and we all know that the applicants, when there are conditions, cannot unilaterally decide not to meet a condition. So together with the amendment to the staff memorandum that I mentioned before about Boston Street Clinic, staff is recommending that we compliment the hospital, the consumer group, and the Lynn Health Task Force, on their efforts and what has gone into it, in terms of energy,

hours, thrashing things out, and the progress they have made. And also to ask that they come back in a year to update the Council on their progress.”

Next, Ms. Lori Long, Esq., Senior Vice President of Strategic and Community Relations, N.S.M.C., said in part, “...I took a great deal of time talking about what a great job we had done in the past year meeting conditions. You also heard from the Task Force, who spent a long time talking about what more needs to be done....Both of us agree that we have made a great deal of progress in the past two years, and there is a great deal more to be done. We have agreed on the priorities for the upcoming year, and those are the areas which we have not attended to as we may have wanted to. We have run into all sorts of hurdles. But those areas of priority are substance abuse and mental health services, transportation, and various ways of dealing with the free care problems that continue to serve as barriers to the people of Lynn in achieving their health care...”

Ms. Leslie Greenberg, Chair, Lynn Health Task Force, accompanied by Steve Rosenfeld, Counsel, Health Law Advocates, said in part, “...This second year of working on the conditions that were set by the Public Health Council has not been the same as last year. We have had some great successes, including the opening of a walk-in center in our downtown area that now has four physicians. And a free care campaign that we worked on with the hospital and the health center, which far exceeded our expectations....The Task Force will continue to commit themselves to working with the hospital, having our monthly meetings, working in many of the subgroups that we have so that we can get to the basis of whatever problems we have, and to continue the successes that we have had. What we have found disappointing is, as has been mentioned before, that there is no pharmacy drug program in place, and that the commitment of specialty doctors to serve free care patients is only in its very early stages. The hospital has actually assisted the only community health center in getting a large grant so that they can serve about half of their free care patients, but the rest of the community is underserved. There is no program for them. I believe that one of the most frustrating problems that we see in Lynn, an old city that has one of the highest drug rates, is that there are no substance abuse programs at all in place, and no substance abuse beds so that people have to go out of the city in order to get help. This is really a disgrace...We have had concerns about services and staff that are slowly being moved out of the hospital....Because of these concerns, we respectfully ask the Public Health Council to oversee this whole process for another year, and allow all of us to come back to report.”

Attorney Steven Rosenfeld, Lynn Task Force, said in part, “...Things are happening in Lynn that simply would not have happened with these conditions, and have never happened before in Lynn, and they are wonderful. It’s wonderful that we are fighting over something that is a much higher bar than it was prior to these conditions. These are excellent signs of progress...We can congratulate Partners for being a terrific health care system, but recognize that institutionally, and structurally, it’s vital that you keep the heat on them so that complacency will not set in. There is no complacency now at Partners...Secondly, a walk-in center opened in Lynn. This is a fantastic new capital structure for Lynn. Partners, Atlanticare, the Lynn Health Task Force are all to be congratulated. There is nothing else like this going on. It was the Public Health Council

and the conditions that made it happen. 3.1 million dollars was spent for a capital structure in downtown Lynn for a walk-in center, so anyone who needs health care in Lynn can come into the walk-in center, which is now staffed by four primary care physicians who were not there in the past, in a city that is notorious for being short of primary care physicians...”

Chairman Koh concluded, “...It seems the consensus is that there is good discussion and dialogue, and that we have made substantial progress in a number of areas. We still have a ways to go, but the process is a good one, and the communication is ongoing....”

After consideration, upon motion made and duly seconded, it was voted: [Chairman Koh, Ms. Kearney-Masaschi, Mr. George, Mr. Rubin, Mr. Sherman, Ms. Slemenda, Dr. Sterne abstained; [Dr. Askinazi and Mr. Sneider not present to vote] to **approve the Request of Previously Approved DoN Project No. 6-3942 of AtlantiCare Medical Center – Progress Report on Compliance with Conditions of Approval for Transfer of Ownership and to return to Council in one year with a progress report.**

The application provides for the transfer of ownership and original licensure of AtlantiCare Medical Center, Inc., resulting from a Memorandum of Understanding between AtlantiCare Medical Center, Inc., AtlantiCare Corporation, North Shore Medical Center, Inc., and Partners HealthCare System, Inc. in which North Shore Medical Center, Inc. will become the sole member of AtlantiCare Medical Center, Inc., AtlantiCare Medical Center, Inc. will remain the licensee of the Hospital.

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Howard Koh, M.D., Chairman  
Public Health Council

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